STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		A. BUI	LDING	ONSTRUCTION 00	(X3) DATE COMPL 01/31/	ETED	
	PROVIDER OR SUPPLIE	L R CUTE REHABILITATION CENTER	B. WIN	STREET A	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD APOLIS, IN 46260	<u> </u>	
(X4) ID PREFIX TAG	(EACH DEFICIE)	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)		ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	(X5) COMPLETION DATE
F0000	This visit was Complaint IN0 Complaint: IN0 Substantiated deficiencies re	for the Investigation of 0121384. 20121384 Federal/State elated to the allegation 57, F279, F281, F309. ciency cited. 31, 2013 er: 000195 ber: 155298 100267690 Fischer RN type: Type:	F00				

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE

Any defiencystatement ending with an asterisk (*) denotes a deficency which the institution may be excused from correcting providing it is determined that other safegaurds provide sufficient protection to the patients. (see instructions.) Except for nursing homes, the findings stated above are disclosable 90 days following the date of survey whether or not a plan of correction is provided. For nursing homes, the above findings and plans of correction are disclosable 14 days following the date these documents are made available to the facility. If deficiencies are cited, an approved plan of correction is requisite to continued program participation.

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID:

5YGC11

Facility ID:

000195

TITLE

(X6) DATE

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2013			
	PROVIDER OR SUPPLIEI D POINT POST-AC	UTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
(X4) ID PREFIX TAG	(EACH DEFICIEN REGULATORY OF	TATEMENT OF DEFICIENCIES ICY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	(X5) COMPLETION DATE			
TAG	These deficien findings cited i IAC 16.2. Quality Review	cies reflect state n accordance with 410 v completed by Tammy ebruary 5, 2013.	TAG	CROSS-REFERENCED TO THE APPROPRI. DEFICIENCY)				

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Event ID: 5YGC11

Facility ID: 000195

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	T OF DEFICIENCIES OF CORRECTION	X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) M	ULTIPLE CO	INSTRUCTION 00	(X3) DATE : COMPL	
ANDIEM	or connection	155298	A. BUII B. WIN			01/31/	
NAME OF D	ROVIDER OR SUPPLIE	D	B. WIN	_	ADDRESS, CITY, STATE, ZIP CODE		
		CUTE REHABILITATION CENTER			DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG E0156		R LSC IDENTIFYING INFORMATION) 0) 483 10(b)(1)		TAG	DEFICIENCY)		DATE
F0156 SS=E	CHARGES The facility must orally and in writ resident understall rules and region conduct and resign the facility. The resident with State developed Act. Such notificor upon admissions tay. Receipt of amendments to writing. The facility must entitled to Medicate time of admisor, when the resident may amount of charged; services that the the resident may amount of charge inform each resident may amount of charge inform each resident may amount of charge inform each resident may amount of charge for the included in nursi state plan and for not be charged; services that the the resident may amount of charge inform each resident may amount of charge inform each resident may amount of charge for the periodically durir services available charges for services available charges for services or by the services or services or by the services are services or services	inform the resident both ing in a language that the ands of his or her rights and ulations governing resident ponsibilities during the stay me facility must also provide the notice (if any) of the under §1919(e)(6) of the cation must be made prior to on and during the resident's such information, and any it, must be acknowledged in inform each resident who is aid benefits, in writing, at assion to the nursing facility ident becomes eligible for tems and services that are mg facility services under the or which the resident may those other items and facility offers and for which the becharged, and the est for those services; and dent when changes are as and services specified in the position of the services, including any idea in the facility and of the services, including any idea in the facility's per diem rate.					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPL	E CONSTRU	JCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DUILI DING	00		COMPL	ETED
		155298	A. BUILDING B. WING			01/31/	2013
			_	ET ADDDE	SS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIE	₹			SHIP LINE RD		
DVDAMIR		CUTE REHABILITATION CENTER			IS, IN 46260		
FIRAWIL	D FOINT FOST-AC	OTE REHABILITATION CENTER	IND	ANAFOL	-13, 114 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL	PREFIX		EACH CORRECTIVE ACTION SHOULD BE OSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
	-	he manner of protecting under paragraph (c) of this					
	section;						
	-	he requirements and					
	procedures for establishing eligibility for						
		ng the right to request an					
		er section 1924(c) which					
		xtent of a couple's urces at the time of					
	•	n and attributes to the					
		se an equitable share of					
	• •	cannot be considered					
	available for pay	ment toward the cost of the					
	institutionalized s	spouse's medical care in his					
		spending down to					
	Medicaid eligibilit	ty levels.					
	A posting of nam	es, addresses, and					
	telephone number	ers of all pertinent State					
		groups such as the State					
		ication agency, the State					
		he State ombudsman					
		tection and advocacy					
		Medicaid fraud control unit;					
		that the resident may file a e State survey and					
	-	cy concerning resident					
		and misappropriation of					
		in the facility, and					
		with the advance directives					
	requirements.						
	The facility must	comply with the					
		ecified in subpart I of part					
		er related to maintaining					
	written policies a	nd procedures regarding					
		es. These requirements					
	-	s to inform and provide					
		on to all adult residents					
		ght to accept or refuse					
	medical or surgic	al treatment and, at the					

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155298	B. WIN			01/31/	2013
		<u> </u>	B. WIIV		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF F	PROVIDER OR SUPPLIEI	R			OWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	CUTE REHABILITATION CENTER			IAPOLIS, IN 46260		
			1		0,0_00		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5)
PREFIX	`	NCY MUST BE PRECEDED BY FULL		PREFIX	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG	BLI ICILIACI)		DATE
		n, formulate an advance cludes a written description					
		plicies to implement					
		es and applicable State law.					
	The facility must inform each resident of the name, specialty, and way of contacting the physician responsible for his or her care. The facility must prominently display in the facility written information, and provide to						
	1						
	residents and applicants for admission oral and written information about how to apply for and use Medicare and Medicaid benefits,						
		ve refunds for previous					
		ed by such benefits.					
	Based on reco	rd review and	F01	56	F 156		02/20/2013
	interview, the f	acility failed to ensure			It is the practice of Pyramid Po	oint	
		wly admitted resident's			to inform the resident of his or	her	
		mbers were fully			rights and all rules and		
		gard to changes for			regulations governing resident	İ	
	l -	on the dementia unit.			conduct and responsibilities during the stay in the facility.		
	1				What corrective actions will	he	
		ely impaired residents			taken for those residents wh		
		to the secured			have been found to have bee	-	
		the facility failed to			affected by the deficient		
	·	ormation related to			practice?		
	l ·	admission and			The responsible families for		
	discharge crite	ria that would effect the			residents F, G, H, I,		
	continued stay	of the resident, on the			J,K,L,M,N,O,P,Q,R and S hav		
	unit for 14 of 1	4 supplemental			been mailed the revised "Bed	and	
		ents. (Resident's "F",			Breakfast Eligibility and Discharge Criteria". Residents	M	
		", "K", "L", "M", "N",			N, and P were assessed agair		
	"O", "P", "Q", "				eligibility for admission to our		
					memory care unit. All three me	et	
	Findings includ	do.			admission criteria.		
		J C .			How other residents having t		
	4 December (1				potential to be affected by th		
	_	entrance conference on			same deficient practice will b		
	01-30-13 at 9:0	00 a.m., the			identified and what correctiv	е	

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.a	00	COMPL	ETED
		155298	A. BUII		·	01/31/	2013
			B. WIN	_	ADDRESS CITY STATE ZID CODE	L	
NAME OF I	PROVIDER OR SUPPLIEF	₹		l	ADDRESS, CITY, STATE, ZIP CODE		
		HITE DELIABILITATION CENTED			OWNSHIP LINE RD		
PYRAWI	D POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE.	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	Administrator i	ndicated the facility			action will be taken?		
	recently "revise	ed" the policy for			Like residents are those who		
	admission and	discharge criteria,			have a need and that meet criteria for admission to our		
	dated 12-27-12	2, for the "Bed and			memory care unit. The		
	Breakfast" (secured dementia) Unit.				pre-screening will be docume	nted	
	,	nterviewed, the			by admissions department if a		
	Administrator indicated the Social				new admit or by social service		
	Service Director was the program				an intra-facility transfer. The "	Bed	
	coordinator for this Unit.				and Breakfast Eligibility and		
	Coordinator for	this Offit.			Discharge Criteria" will be		
					presented to the responsible party prior to or on day admis	oion	
	When interviewed on 01-30-13 at				to memory care unit.	SION	
	9:40 a.m., the Administrator indicated				What measures will be put in	nto	
	the residents and family members				place or what systemic		
	who currently r	resided, and were			changes will be made to		
	admitted to the	e secured Unit prior to			ensure that the deficient		
	12-27-12, had	not been informed of			practice does not reoccur?		
	the "revision."	and further stated, "It			Admissions and Social Service	е	
	· ·	fies who is appropriate			staff have been in-serviced or		
		unit and who is not."			need to pre-screen and prese		
		ariit aria wilo lo riot.			"Bed and Breakfast Eligibility	and	
	Desident/family	y mombors who could			Discharge Criteria" to the responsible party prior to or o	n	
		y members who could			day of admission to our memo		
		the revisions included			care unit.	y	
		"G", "H", "I", "J", "K",			How the corrective action w	II	
	"L", "O", "Q", "I	R" and "S".			be monitored to ensure the		
					deficient practice does not		
	2. Review of t	he previous "Special			reoccur?		
	Care Unit," adı	mission and discharge			ED or designee will monitor		
	criteria on 01-3	30-13 at 10:00 a.m.,	1		pre-screening and signed "Be	a	
	and undated, i	ndicated the following:			and Breakfast Eligibility and Discharge Criteria" prior to or	on	
		_			day admission to the memory		
	"Statement of	Purpose - To recognize			care unit. This will be complet		
	the needs of a special segment of our				weekly times four weeks and		
		ation designed to			monthly times 2 months. At th	is	
		nd treatment to the			time if results are below a 95%		
	-				threshold the audits will become		
	resident experi	iencing ioss of	1		weekly until a 95% threshold	S	

DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH CORRECTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Cognitive-behavioral skills. The achieved. The results will be	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING	(X3) DATE SURVEY COMPLETED - 01/31/2013
PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL PREFIX (EACH ORDRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY) Cognitive-behavioral skills. The achieved. The results will be		8530 TOWNSHIP LINE RD	DDE
and the CAA constitutes	PREFIX (EACH DEFICIENCY MUST BE PRECEDED BY FULL	PREFIX PROVIDER'S PLAN OF CORRI PREFIX (EACH CORRECTIVE ACTION SHC CROSS-REFERENCED TO THE AP DEFICIENCY)	DULD BE COMPLETION PROPRIATE DATE
residents on this unit typically experience a continuum of loss of abilities that often threaten his/her interpersonal relationships, effect decision-making process, and will ultimately no longer be able to use their basic daily living skills. An interdisciplinary approach will be used in all admission/discharge decision. Recommendations are made on an individual basis." "Discharge Criteria: 1. Inability to retain mental or physical skills necessary to ambulate without the use of assistive devices, such as merry walker, wheelchair, can, etc. 2. Acute medical condition that would required close observation and assessment by licensed nursing staff to identify or evaluate the residents need for modification of treatment and the initiation of additional medical procedures until the residents condition arising that would warrant the presence of indwelling or external lines, such as, gastrostomy tubes, nasogastric tubes, or infravenous lines or urinary catheters. 4. Resident is not longer at risk of wandering out of the facility or in or our of other resident rooms."	cognitive-behavioral skills. The residents on this unit typically experience a continuum of loss of abilities that often threaten his/her interpersonal relationships, effect decision-making process, and will ultimately no longer be able to use their basic daily living skills. An interdisciplinary approach will be used in all admission/discharge decision. Recommendations are made on an individual basis." "Discharge Criteria: 1. Inability to retain mental or physical skills necessary to ambulate without the use of assistive devices, such as merry walker, wheelchair, can, etc. 2. Acute medical condition that would required close observation and assessment by licensed nursing staff to identify or evaluate the residents need for modification of treatment and the initiation of additional medical procedures until the residents condition is stabilized. 3. Medical condition arising that would warrant the presence of indwelling or external lines, such as, gastrostomy tubes, nasogastric tubes, or intravenous lines or urinary catheters. 4. Resident is not longer at risk of wandering out of the facility or in or	achieved. The results w reviewed by QAA comm monthly. Date to be completed	ill be

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STATEMEN	NT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MULTI	IPLE CO	NSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII DIN	IC.	00	COMPL	ETED
		155298	A. BUILDIN B. WING	U		01/31/	2013
		1		TREET A	DDRESS, CITY, STATE, ZIP CODE		
NAME OF I	PROVIDER OR SUPPLIEF	₹			OWNSHIP LINE RD		
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES	II)	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		ICY MUST BE PRECEDED BY FULL		EFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)	TA	AG	DEFICIENCY)		DATE
	3. The "revise	•					
		t Memory Care at the					
	Bed and Breakfast Eligibility and						
	_	eria," and dated					
	12-27-12, indic	cated the following:					
	"The admission criteria is the standard by which the Memory Care						
		d Breakfast" accepts or					
		al residents and is also					
		riteria by which the					
	resident is to be discharged from the						
	unit. The scre	ening process starts					
	prior to admiss	sion and is ongoing to					
	the time of disc	charge. Each resident					
	admitted on the	e unit enters into a trial					
	period, where	residents are assessed					
	for ongoing ap	propriateness to					
	remain there.	At any point during this					
	time, the facilit	y reserves the right to					
	transfer per the	e listed criteria, to					
	another area ir	n our facility. Specific					
	admission crite	eria is required for the					
	Memory Care	at the "Bed and					
	Breakfast;" to	effectively meet the					
	needs of the re	esidents who can					
	benefit from th	e services provided.					
		imilar needs and					
	functioning lev	els can best be served					
	_	esidents with similar					
		tion. Any resident that					
	_	sive direct care; (in					
		and grooming) may					
	not benefit from						
		Their needs may be					
	l brogrammig.	Their fields thay be					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155298	B. WIN			01/31/	2013
			D. W.I.		ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER	S.			OWNSHIP LINE RD		
PYRAMI	POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	better met in ar facility."	nother area of the					
	assessment tea	ocess [bold type] - The am will conduct a assessment with the rty and potential					
	Those individual psychiatric diagillness. Alcohol Parkinson's, Fr Lewy Bodies a not be conside the uniqueness processes and an individual baperson who ex self or others a behaviors that environment. Vand walkers wiindividual basis require a mech resident who is Care at the "Betube feedings, individually assappropriateness."	rontal Lobe Injury, and Picks Disease may red appropriate due to s of the disease will be considered on asis for placement. A hibits physical harm to and/or exhibits disrupt the living Wheelchairs, canes Il be reviewed on an as. Residents that annical lift. Each a referred to Memory and Breakfast" with or an ostomy will be asessed for their ass."					
	and underscore	om the Unit [bold type ed] - In determining if a ger meets the criteria,					

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	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER: 155298	A. BUI	LDING	00	COMPLE 01/31/2	
		155296	B. WIN			01/31/2	2013
NAME OF P	ROVIDER OR SUPPLIER	S.			ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID	SUMMARY S'	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	``	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ΓE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)	+	TAG	DEFICIENCY)		DATE
	_	ay be taken into					
		Programming - a					
		oe benefiting from Behaviors - A person					
		nysical harm to self or					
		whibits behaviors that					
		ig environment. Any					
	•	equires extensive direct					
		bathing and grooming					
	_	t from specialized					
		heir needs may be					
	better met in a	nother area of the					
	facility."						
		1" was admitted to the					
		2-13. The record					
	lacked docume						
		assessment was					
		r to admission. In					
	•	Pyramid Point Memory					
		d and Breakfast					
		Discharge Criteria," was amily member on					
	,	he Initial Social Service					
		as dated 01-29-13.					
	7.00003iiiCiit, W	740 44104 01 20-10.					
	5. Resident "N	N" was admitted to the					
		0-13. The record					
	lacked docume						
	"prescreening"	assessment was					
	completed prio	r to admission. In					
	addition, the "F	Pyramid Point Memory					
	Care at the Be	d and Breakfast					
	Eligibility and D	Discharge Criteria," was					
	signed by the f	amily member on					

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	STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIE	R CUTE REHABILITATION CENTER	8530 1	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD NAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIE	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
		the Initial Social sment, was dated			
	facility on 01-1 lacked docum "prescreening" completed prid addition, the "I Care at the Be Eligibility and signed by the 01-17-13 and	P" was admitted to the 15-13. The record entation a " assessment was or to admission. In Pyramid Point Memory ed and Breakfast Discharge Criteria," was family member on the Initial Social Service was dated 01-22-13.			

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN (OF CORRECTION	IDENTIFICATION NUMBER:	A DIJII	DDIC	00	COMPL	ETED
		155298	A. BUILI			01/31/	2013
			B. WINC	_	DDDEGG CITY CTATE ZID CODE		
NAME OF P	ROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
D) (D 4441					OWNSHIP LINE RD		
PYRAMIL	POINT POST-AC	UTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	I	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT	ſĘ	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0157	483.10(b)(11)						
SS=D	NOTIFY OF CHA	NGES					
	(INJURY/DECLIN	NE/ROOM, ETC)					
		mediately inform the					
		with the resident's					
		known, notify the resident's					
	legal representative or an interested family						
		ere is an accident involving					
		h results in injury and has					
	•	equiring physician					
		gnificant change in the al, mental, or psychosocial					
		erioration in health, mental,					
	•	status in either life					
	threatening condi						
	_	need to alter treatment					
	•	a need to discontinue an					
		reatment due to adverse					
	•	r to commence a new form					
	•	a decision to transfer or					
	discharge the res	ident from the facility as					
	specified in §483.	.12(a).					
	•	also promptly notify the					
		nown, the resident's legal					
	•	interested family member					
	when there is a c	_					
	-	ment as specified in					
		a change in resident rights					
		State law or regulations as					
	specified in parag	graph (b)(1) of this section.					
	The facility must	record and periodically					
		ss and phone number of					
	•	al representative or					
	interested family						
	•	rd review and interview	F015	57	F 157		02/20/2013
		d to ensure physician	1015	, ,	It is the practice of Pyramid Po	int	02/20/2013
	•	. ,			to contact a patient's physiciar		
		family notification, in			and Family when the patient h		
		sident who was			an accident involving injury and		
	assessed with	lower extremity edema,			has the potential for requiring		
			l				l l

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5YGC11

Facility ID: 000195

If continuation sheet Page 12 of 31

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	Δ D IIII	LDING	00	COMPL	ETED
		155298	B. WIN			01/31/	/2013
		1	D. 1111		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF F	PROVIDER OR SUPPLIE	R			OWNSHIP LINE RD		
	D POINT POST-AC	CUTE REHABILITATION CENTER			IAPOLIS, IN 46260		
(X4) ID	SUMMARY S	STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX		NCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRI DEFICIENCY)	ATE	COMPLETION
TAG		R LSC IDENTIFYING INFORMATION)		TAG			DATE
		embolytic stocking			physician intervention and wh		
	(Elastic Stocki	ngs), the nursing staff			patient has a significant chan physical, mental, or psychoso	-	
	failed to inform	n the physician for			status.	Julai	
	possible interv	ention and family			What corrective actions will	be	
	l •	the increased edema,			taken for those residents will		
		ation the stocking			have been found to have be		
		esident's thigh, for 1 of			affected by the deficient		
	3 resident's re				practice?		
					Resident A has been dischar	ged	
	1	stockings in a sample of			from the facility.		
	5. (Resident ".	A").			How other residents having		
					potential to be affected by t		
Findings include:				same deficient practice will			
					identified and what correcti	ve	
	1. The record	for Resident "A" was			action will be taken?		
	reviewed on 0	1-30-13 at 9:50 a.m.			Like residents are those who	on	
		luded but were not			have had a change in condition and have the potential for	OH	
	•	ere degenerative joint			physician intervention. Nursir	na	
		-			staff will notify physician and	19	
		entia, depression			family when a resident has a		
	••	ascites, hepatitis C,			change in condition; This		
		art failure and cirrhosis.			notification will be documented	ed on	
	-	ses remained current at			the change of condition SBAI		
	the time of the	record review.			What measures will be put i	nto	
					place or what systemic		
	A physician or	der dated 10-12-12,			changes will be made to		
	instructed the	nursing staff, "daily			ensure that the deficient		
		pt. [patient] gains 3 lbs			practice does not reoccur? Licensed nursing staff have be	neen	
	1	od or 5 lbs. [pounds] in			in-serviced on the need to no		
	1 week."	ou of o loo. [pourido] in			physician and family if the pa	-	
	I WCCK.				has a significant change in		
	Doving of a la	aal araa nhusisian			physical, mental, or psychoso	ocial	
		cal area physician			status.		
		al Summary," dated			How the corrective action w	rill	
		14 p.m., indicated the			be monitored to ensure the		
	patient is [age	e documented] who			deficient practice does not		
	presents with a	ascites. The patient			reoccur?		
	was referred b	y a primary care			DON or designee will monitor	ſ	

STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	
		155298	B. WINC			01/31/	2013
NAME OF P	PROVIDER OR SUPPLIER				ADDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD		
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)]	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	COMPLETION
TAG		<u> </u>		TAG	resident's with change of		DATE
	·	I presentation was 6 Presentation included			condition to ensure notification	of	
	, , ,	n. Past evaluation has			physician and family. This will	be	
		nin, complete blood			completed weekly times four weeks and then monthly times	2	
	count and meta	•			months. At this time if results a		
	Treatment has				below a 95% threshold the aud	dits	
	restriction and	furosemide [a diuretic			will become weekly until a 95%		
	medication]. S	ymptoms include			threshold is achieved. The res will be reviewed by QAA	uitS	
	abdominal dist	ention, weight gain and			committee monthly.		
	peripheral ede	ma"			Date to be completed		
					2/20/2013		
		umentation of the					
	_	weights for December					
	2012 included	•					
		.5 lbs, 12-21-12 - 174					
	108, 12-22-12 - 177 lbs.	177.2 lbs, 12-23-12 -					
	177 105.						
	Nurses note, d	ated 12-22-12, at 6:30					
		t wgt. [weight] 177.2,					
		s from yesterday.					
		es] to have 2+ edema					
	bil. [bilateral] lo	wer extremities. TED					
	[antiembolytic	stockings] on. [Name					
	of physician] no	otified."					
	Niumanat	atad 40 00 40 at 40:40					
	•	ated 12-22-12 at 10:46					
		"BLE [bilateral lower					
	,	na 2 + but Rt. [right] approximately] 3+.					
	•	too small, but they are					
		Removed at 2:15					
		pand creating indention					
	(sic) on Rt. thig	_					
	(,					

FORM CMS-2567(02-99) Previous Versions Obsolete

Event ID: 5YGC11

Facility ID: 000195

If continuation sheet Page 14 of 31

STATEMENT OF DEFICIENCIES XI) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CO A. BUILDING	(X3) DATE SURVEY COMPLETED 01/31/2013		
		100200	B. WING	ADDRESS STEW STATE STREET	31/31/2013
NAME OF P	PROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD	
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER		IAPOLIS, IN 46260	
(X4) ID		FATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	TE COMPLETION DATE
	resident's phys party had beer	ked documentation the ician or responsible notified of the			
	that the stockin	na to the right thigh, or ig had made an he resident's upper			
	leg.				
	2:00 p.m., the I	nterview on 01-31-13 at Director of Nurses cumentation lacked cation.			
	Nurses and As Nurses indicate provide docum measurements when the resid	nal interview on 100 p.m., the Director of sistant Director of 2d they were unable to 2d they were unable to 2d they been obtained 2d they been obtained 2d they been to 2d they been obtained 2d they been at 5d the right thigh.			
	company only vendor] and the extra large. W	Nurses indicated "our uses [name of a certain e size only goes to e probably should have ering from some one			
	provided by the indicated the fo	5 p.m., and undated, Director of Nurses Blowing:			
	"BASIC RESP(ONSIBILITY - Licensed			

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Event ID: 5YGC11

Facility ID: 000195

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MU	LTIPLE CO	NSTRUCTION	(X3) DATE	SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUIL	DING	00	COMPL	ETED
		155298	B. WINC			01/31/	2013
NAME OF P	ROVIDER OR SUPPLIEI	R	<u> </u>		ADDRESS, CITY, STATE, ZIP CODE	•	
					OWNSHIP LINE RD		
PYRAMIL	POINT POST-AC	CUTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID		STATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX TAG	`	NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	'	PREFIX TAG	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	ATE	COMPLETION DATE
TAG		rsing Assistant, Other		TAG			DATE
	"	sing Assistant, Other					
							
	"PURPOSE - T	To provide support for					
		es, to aid return					
		n lower extremities, to					
		us formation, to reduce					
	pain, and redu						
		IT GUIDELINES - may					
		e not limited to: Change					
	•	d/or mental function,					
		eripheral pulses, fever,					
	•	integrity, color,					
	•	edema, changes in					
	condition of ex	tremities."					
	"PROCEDURE	E - 6. Notify physician if					
		will not fit: obtain order					
		de gradient support					
	stockings."	3					
	-						
	4. Review of f	acility policy on					
	01-31-13 at 8:2	20 a.m., titled					
		re Operating Standard					
	0 0	inge of Condition," and					
		2011, indicated the					
	following:						
	IIObio eti e II I	d turno and					
	"Objective [bol	· ·					
	-	To appropriately					
	•	nent, and communicate ndition (COC), to the					
	•	rovider. To provide					
		services to address					
	u eaunent and	services to address	1				

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Event ID: 5YGC11

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If continuation sheet

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STATEMEN	T OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A DITT	LDING	00	COMPL	ETED
		155298	B. WIN			01/31/	2013
			b. WIIN		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	ROVIDER OR SUPPLIER	L			DWNSHIP LINE RD		
		UTE REHABILITATION CENTER			APOLIS, IN 46260		
FTRAMIL	J POINT POST-AC	OTE REHABILITATION CENTER		INDIAN	APOLIS, IN 40200		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	changes in acc	cordance with resident					
	needs and exis	sting Advance					
	Directives."	9					
	2						
	"Practice Stand	dards [bold type and					
		= · · · · · · · · · · · · · · · · · · ·					
	_	If the change in					
	condition does						
	_	e following steps may					
		. Notify physician and					
	responsible pa	rty of assessment					
	findings. 3. No	otify the Resident					
	_	sible party of current					
	status and sub						
	actions/orders.						
	actions/orders.						
	This Factoral to	a and the safe On an also int					
		g relates to Complaint					
	IN00121384.						
	3.1-5(a)						

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Event ID: 5YGC11

Facility ID: 000195

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) MU	LTIPLE CO	ONSTRUCTION	(X3) DATE	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	, DIIII	DDIG	00	COMPL	ETED
		155298	A. BUIL			01/31/	2013
			B. WINC		ADDRESS CITY STATE ZID CODE		
NAME OF P	PROVIDER OR SUPPLIE	R			ADDRESS, CITY, STATE, ZIP CODE		
	DOINT DOCT AC	NITE DELIADII ITATION CENTED			ADOLIG IN 46260		
PYRAMIL	J POINT POST-AC	CUTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY	STATEMENT OF DEFICIENCIES	ID		PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIE)	NCY MUST BE PRECEDED BY FULL	1	PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY O	R LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0279	483.20(d), 483.2						
SS=D		IPREHENSIVE CARE					
	PLANS						
	,	se the results of the					
		evelop, review and revise					
	the resident's co	mprehensive plan of care.					
	The facility must	develop a comprehensive					
		ch resident that includes					
		ectives and timetables to					
	-	s medical, nursing, and					
	mental and psyc	hosocial needs that are					
	identified in the	comprehensive assessment.					
	The care plan m	ust describe the services					
	that are to be fur	nished to attain or maintain					
		ghest practicable physical,					
		chosocial well-being as					
		483.25; and any services					
		wise be required under					
	_	not provided due to the					
		se of rights under §483.10, nt to refuse treatment under					
	§483.10(b)(4).	it to reluse treatment under					
		ervation and record	F027	79	F 279		02/20/2013
		ility failed to ensure the			It is the practice of Pyramid Po	oint	
		of a comprehensive			to develop, review and revise		
	•	or residents who had a			resident's comprehensive plar	n of	
		er extremity edema, and			care.	L -	
	,	olic stocking for 2 of 3			What corrective actions will		
		S .			taken for those residents wh	-	
		ewed for lower extremity			affected by the deficient	:11	
		imple of 5. (Resident			practice?		
	"A" and "E").				Resident A has been discharg	ed	
					from the facility. A care plan for		
	Findings inclu	de:			dependent edema, including		
	-				measurable goals and specific		
	1. The record	for Resident "A" was			interventions has been develo	ped	
		1-30-13 at 9:50 a.m.			and implemented for Resident		
					How other residents having t	the	
	ו שפטווטses inc	luded but were not	1		potential to be affected by th	e	

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Event ID: 5YGC11

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:		nn.c	00	COMPL	ETED
		155298	A. BUIL			01/31/	2013
			B. WIN		DDDEGG GVEV GEATE ZID GODE		
NAME OF I	PROVIDER OR SUPPLIEI	₹			ADDRESS, CITY, STATE, ZIP CODE		
D) (D 4 1 4	D DOWLT DOOT 4.0	WITE DELIABILITATION OF NITED			OWNSHIP LINE RD		
PYRAMI	D POINT POST-AC	CUTE REHABILITATION CENTER		INDIAN	APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	ICY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	ATE.	COMPLETION
TAG	REGULATORY OF	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	limited to, seve	ere degenerative joint			same deficient practice will I	эе	
		entia, depression			identified and what correctiv	'e	
		ascites, hepatitis C,			action will be taken?		
		art failure and cirrhosis.			Like residents are those who		
	_				have dependent edema. Care		
	_	ses remained current at			plans have been developed a		
	the time of the	record review.			implemented for all residents		
					dependent edema that include		
	Review of a lo	cal area physician			measureable goals and specifications.	IC	
	report "Clinical	Summary," dated			What measures will be put in	nto	
	11-29-12. at 4:	14 p.m., indicated the			place or what systemic	110	
		documented] who			changes will be made to		
		ascites. The patient			ensure that the deficient		
	·	•			practice does not reoccur?		
		y a primary care			Licensed nursing staff have be	een	
	•	nl presentation was 6			in-serviced on the need for ca		
	` ' •	Presentation included			plans for residents with		
	fluid weight ga	in. Past evaluation has			dependent edema that include	.	
	included albun	nin, complete blood			measureable goals and specif	ic	
	count and met	abolic profile.			interventions.		
	Treatment has	included fluid			How the corrective action wi	II	
	restriction and	furosemide [a diuretic			be monitored to ensure the		
		Symptoms include			deficient practice does not		
	_	ention, weight gain and			reoccur? DON or designee will monitor		
					residents with dependent ede		
	peripheral ede	IIIa			for current and updated care	iii a	
	1				plans that include measureab	le	
	Nurses note, d	lated 12-22-12 at 6:30			goals and specific intervention		
	a.m., "Residen	it wgt. [weight] 177.2,			This will be completed weekly		
	increase 3.2 lb	s from yesterday.			times four weeks and then		
	Cont. [continue	es] to have 2+ edema			monthly times 2 months. At th		
	_	ower extremities. TED			time if results are below a 95%		
		stockings] on. [Name			threshold the audits will becor		
	of physician] n	- -			weekly until a 95% threshold i achieved. The results will be	S	
	or priyaiciarij ii	ouncu.			reviewed by QAA committee		
	Number	-t			monthly.		
	•	lated 12-22-12 at 10:46			Date to be completed		
	•	BLE [bilateral lower			2/20/2013		
	extremity] ede	ma 2 + but Rt. [right]					

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Event ID: 5YGC11

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If continuation sheet

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA			(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUI	LDING	00	COMPLI	
		155298	B. WIN			01/31/	2013
NAME OF P	PROVIDER OR SUPPLIER	1			ADDRESS, CITY, STATE, ZIP CODE		
DVDAMI		UTE REHABILITATION CENTER			DWNSHIP LINE RD APOLIS, IN 46260		
					AI OLIO, IIV 40200		
(X4) ID PREFIX		TATEMENT OF DEFICIENCIES CY MUST BE PRECEDED BY FULL		ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	`	LSC IDENTIFYING INFORMATION)		TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	ΓE	DATE
		approximately] 3+.		_			
	•	too small, but they are					
]. Removed at 2:15					
		and creating indention					
	[sic] on Rt. thig	_					
	The record lack	ked a plan of care in					
	which the spec	ific problem was					
	identified in reg	gard to lower extremity					
	edema, a meas	surable goal, and					
		y the nursing staff to					
		plement for the					
	resident.						
	0 =	. D : (D					
		for Resident "D" was					
		-31-13 at 10:15 a.m.					
	_	uded but were not					
		e dementia with enerative joint disease,					
	_	and chronic pain.					
	''	es remained current at					
	the time of the						
		100014 1041044					
	Observation or	n 01-30-13 at 11:30					
		ent was seated in					
	•	the dining room of the					
	secured demer	•					
	participating in	an activity. The					
	resident wore a	antiembolic stockings.					
	Review of the r	esident's record lacked					
	•	which addressed the					
	resident's depe	endent edema, a					
	measurable go	al, and implement					
	specific interve	ntions.					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298			ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2013
	PROVIDER OR SUPPLIE	R CUTE REHABILITATION CENTER	8530 T	ADDRESS, CITY, STATE, ZIP CODE OWNSHIP LINE RD IAPOLIS, IN 46260	
(X4) ID PREFIX TAG	(EACH DEFICIEN	STATEMENT OF DEFICIENCIES NCY MUST BE PRECEDED BY FULL R LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE
	This Federal to IN00121384. 3.1-35(a) 3.1-35(b)(1)	ag relates to Complaint			

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Event ID: 5YGC11

Facility ID: 000195

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STATEMEN	IT OF DEFICIENCIES	X1) PROVIDER/SUPPLIER/CLIA	(X2) M	JLTIPLE CC	ONSTRUCTION	(X3) DATE SURVEY	
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A RIIII	LDING	00	COMPL	ETED
		155298	B. WIN			01/31/	2013
			D. 1111	_	ADDRESS, CITY, STATE, ZIP CODE	<u> </u>	
NAME OF P	ROVIDER OR SUPPLIER			l	OWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID		TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	`	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG		LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
F0281	483.20(k)(3)(i)	"DED MEET					
SS=D	SERVICES PROV						
	PROFESSIONAL	rided or arranged by the					
		professional standards of					
	quality.	professional standards of					
	• •	rd review and interview	F02	81	F 281		02/20/2013
	the facility faile				It is the practice of Pyramid Po	oint	
	_	andards of care were			to provide or arrange for servi		
	·	that when a resident			that meet professional standar	ds	
	-	ory of lower extremity			of quality.		
		•			What corrective actions will		
		ed antiembolytic			taken for those residents wh have been found to have bee	-	
	٠.	c Stockings], to aid in			affected by the deficient	n	
	_	ema, the nursing staff			practice?		
	failed to perforr	•			Resident A has been discharg	ed	
	-	emeasurement of the			from the facility.		
	resident's legs	and provide stocking			How other residents having t	the	
	which fit and di	d not impede the			potential to be affected by th	е	
	reduction of ed	ema, and which			same deficient practice will b		
	eventually caus	sed an indentation to			identified and what correctiv	е	
	the residents le	g/thigh, for 1 of 3			action will be taken?		
	resident's revie	wed for antiembolytic			Like residents are those who wear anti-embolic stockings. A	VII	
		ower leg edema in a			like residents were measured		
	sample of 5. (F	•			appropriate fitting anti-embolic		
	(,			stockings.		
	Findings includ	e.			What measures will be put in	to	
	. mamgo moraa	<u>.</u>			place or what systemic		
	The record for	Resident "A" was			changes will be made to		
		-30-13 at 9:50 a.m.			ensure that the deficient		
					practice does not reoccur? Licensed nursing staff have be	oen.	
	_	uded but were not			in-serviced on the need to	,611	
		re degenerative joint			assess, measure, and provide	ł	
		ntia, depression			appropriate fitting anti-embolic		
		ascites, hepatitis C,			stockings.		
	congestive hea	irt failure and cirrhosis.			How the corrective action wi	11	
	_	es remained current at			be monitored to ensure the		
	the time of the	record review.			deficient practice does not		

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STATEMEN	TEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) M	ULTIPLE CO	NSTRUCTION	(X3) DATE S	SURVEY
AND PLAN	OF CORRECTION	IDENTIFICATION NUMBER:	A. BUII	DING	00	COMPL	ETED
		155298	A. BUII B. WIN			01/31/	2013
			D. WIIV		ADDRESS, CITY, STATE, ZIP CODE		
NAME OF P	PROVIDER OR SUPPLIEF	2			OWNSHIP LINE RD		
PYRAMII	D POINT POST-AC	UTE REHABILITATION CENTER			APOLIS, IN 46260		
(X4) ID	SUMMARY S	TATEMENT OF DEFICIENCIES		ID	PROVIDER'S PLAN OF CORRECTION		(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)		TAG	DEFICIENCY)		DATE
	A physician ordinstructed their weight - call if pin 48 hour period 1 week." Review of a locate report "Clinical 11-29-12 at 4:7" patient is [age presents with a was referred by provider. Initial month(s) ago. fluid weight gaincluded alburr count and metate Treatment has restriction and medication]. Sabdominal distiperipheral eder Review of docuresident's daily 2012 included 12-20-12 - 164 lbs, 12-22-12 - 177 lbs. Nurses note, da.m., "Residen	der dated 10-12-12, nursing staff, "daily ot. [patient] gains 3 lbs od or 5 lbs. [pounds] in cal area physician Summary," dated 14 p.m., indicated the documented] who ascites. The patient y a primary care I presentation was 6 Presentation included in. Past evaluation has hin, complete blood abolic profile. included fluid furosemide [a diuretic symptoms include ention, weight gain and ma"			reoccur? DON or designee will monitor residents who wear anti-embo stockings for appropriate fit. The will be completed weekly times four weeks and then monthly times 2 months. At this time if results are below a 95% thresh the audits will become weekly until a 95% threshold is achieved. The results will be reviewed by QAA committee monthly. Date to be completed 2/20/2013	nis s nold ved.	
	Nurses note, d a.m., "Residen increase 3.2 lb	t wgt. [weight] 177.2,					

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		(X2) MULTIPLE CO A. BUILDING B. WING	ONSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2013	
NAME OF P	ROVIDER OR SUPPLIER			ADDRESS, CITY, STATE, ZIP CODE	•
PYRAMI	D POINT POST-AC	UTE REHABILITATION CENTER		OWNSHIP LINE RD IAPOLIS, IN 46260	
(X4) ID		TATEMENT OF DEFICIENCIES	ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE	(X5)
PREFIX TAG	`	CY MUST BE PRECEDED BY FULL LSC IDENTIFYING INFORMATION)	PREFIX TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	COMPLETION DATE
TAG	bil. [bilateral] lo [antiembolytic sof physician] no Nurses note, di p.m., indicated extremity] eder thigh approx. [a TED hose are to XL [extra large p.m. after top be [sic] on Rt. thigh approx. [a TED hose are to XL [extra large p.m. after top be [sic] on Rt. thigh approx. [a TED hose are to XL [extra large p.m. after top be [sic] on Rt. thigh approx. The During an indicated she we documentation measurements due to the increasing thigh. The Director of company only ovendor] and the extra large. We seen about ordelse." 3. Review of fa 01-31-13 at 1:444 provided by the indicated the formal indicated the face of the indicated the indicated the indicated the face of the indicated the face of the indicated the indica	ewer extremities. TED stockings] on. [Name officed." ated 12-22-12 at 10:46 "BLE [bilateral lower ma 2 + but Rt. [right] approximately] 3+. too small, but they are]. Removed at 2:15 orand creating indention h." aterview on 01-31-13 at Director of Nurses was unable to provide the resident's had been obtained ease in edema to the A Nurses indicated "our uses [name of a certain esize only goes to be probably should have dering from some one decility policy on the spirate of the process of the probably should have dering from some one decility policy on the process of	TAG		
		ONSIBILITY - Licensed sing Assistant, Other			

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STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	00		r í	(3) DATE SURVEY COMPLETED		
		155298		LDING G		01/31/2013		
NAME OF I	DDOVIDED OD GUDDI IEI		B. WIIV		DDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER			8530 TOWNSHIP LINE RD					
PYRAMID POINT POST-ACUTE REHABILITATION CENTER				INDIAN	APOLIS, IN 46260			
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION	
PREFIX TAG				PREFIX (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIAT DEFICIENCY)		TE DATE		
	."	,						
	"PURPOSE - 1	To provide support for						
		es, to aid return						
		n lower extremities, to						
		us formation, to reduce						
	pain, and redu	ce edema.						
	"ASSESSMEN	IT GUIDELINES - may						
		not limited to: Change						
	in physical and	l/or mental function,						
		eripheral pulses, fever,						
	_	integrity, color,						
	•	dema, changes in						
	condition of ex	tremities."						
	 "PROCEDURE	E - 6. Notify physician if						
		will not fit: obtain order						
	for custom-ma	de gradient support						
	stockings."							
		eference data related						
	Care of Patien	stockings titled, "The						
		stockings," on 01-31-13						
		nd dated July 2008,						
	indicated the fo							
		-						
		for patients wearing						
	stockings must read and follow							
		manufacturers						
	instructions."							
	 "Following the	assessment of patients						
	_	se can delegate						

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STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION (X3) DATE SUR					
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING 00 COMPLETED					
		155298	B. WIN	G		01/31/	2013
NAME OF PROVIDER OR SUPPLIER					ADDRESS, CITY, STATE, ZIP CODE		
PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
			1	<u> </u>	711 OLIO, 111 40200		(7/5)
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)			ID PREFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG				TAG CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)			DATE
	subsequent ca	re to all other members					
	of the team including unqualified staff,						
	but must ensur	re that the staff					
	member is awa	are of risk and					
	•	safety checks during					
	each episode o						
		to ensure that the					
		rers receive appropriate					
		d education regarding					
		embolic stockings. All					
		agement must be					
	plan."	e patient's notes/care					
	ριαπ.						
	"Document me	easurements and size					
		at assessment to					
	_	line measure. Leg					
		s will need to be					
	checked to avo	oid potential					
	complications i	related to swelling of					
	the leg causing	g excessive pressure					
	from the stocki	ngs."					
		es of subsequent					
	_	tockings should be					
		sure correct placement					
		ng ensuring that they					
	do not impair the						
	Patients should be monitored sitting out of the bed to ensure the stocking is not restricting the circulation at the knee."						
	"Pain or discor	mfort should be					
	assessed, mor	nitored and reported					

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		(X2) MULTIPLE CONSTRUCTION (X3) DATE SURVEY							
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		A. BUILDING	00	COMPLETED					
	155298				01/31/2013				
NAME OF F	PROVIDER OR SUPPLIEI	R		ADDRESS, CITY, STATE, ZIP CODE					
DVDVIVII	PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260					
				AI OLIO, IIN 1 0200	(X5)				
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID PROVIDER'S PLAN OF CORRECTION PREFIX (EACH CORRECTIVE ACTION SHOULD BE					
TAG	•	R LSC IDENTIFYING INFORMATION)	TAG	CROSS-REFERENCED TO THE APPROPRIA' DEFICIENCY)	COMPLETION DATE				
	immediately to	*			2332				
	•	nd the stockings							
	removed."	g-							
	"Education of t	the patient and							
	appropriate ca	rers should be an							
		of the care provided							
		ompass issues such as							
		wearing stockings,							
	_	and application, care of							
		eed to make safety							
	and movemen	ulation, swelling, pain							
	and movemen	is.							
	This Federal ta	ag relates to Complaint							
	IN00121384.	ag related to complaint							
	3.1-35(g)(1)								
	(6)()								

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AND PLAN OF CORRECTION IDENTIFICATION NUMBER: 155298		X2) MULTIPLE CONSTRUCTION A. BUILDING B. WING STREET ADDRESS, CITY, STATE, ZIP CODE X3) DATE SURVEY COMPLETED 01/31/2013			ETED		
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8530 TOWNSHIP LINE RD				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID PROVIDER'S PLAN OF CORRECTION			(X5)
PREFIX	(EACH DEFICIEN	CY MUST BE PRECEDED BY FULL	PREFIX		(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	TE	COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	TAG		DEFICIENCY)		DATE
F0309 SS=D	HIGHEST WELL Each resident mu must provide the services to attain practicable physic psychosocial well the comprehensiv care. Based on record the facility faile was assessed highest practic of care. When history of lower used antiembo Stockings), to a edema, the nur perform comple remeasuremer and provide sto not impede the and caused an resident's revie stockings and I sample of 5. (I Findings include 1. The record reviewed on 01 Diagnoses incl limited to, seve disease, deme	ast receive and the facility necessary care and or maintain the highest cal, mental, and labeling, in accordance with re assessment and plan of a review and interview do to ensure a resident and received the all physical and quality a resident who had a rextremity edema, and lytic stocking (Elastic aid in decreasing raing staff failed to eat assessment, at of the resident's legs ocking which fit and did decrease of edema, indentation to the high, for 1 of 3 ewed for antiembolytic ower leg edema in a Resident "A").	F030	09	F 309 It is the practice of Pyramid Poto provide all residents with the necessary care and services thattain or maintain the highest practicable physical, mental and psychosocial well-being. What corrective actions will taken for those residents who have been found to have been affected by the deficient practice? Resident A has been discharge from the facility. How other residents having the potential to be affected by the same deficient practice will be identified and what corrective action will be taken? Like residents are those who wear anti-embolic stockings. A like residents were measured appropriate fitting anti-embolic stockings. What measures will be put in place or what systemic changes will be made to ensure that the deficient practice does not reoccur? Licensed nursing staff have be in-serviced on the need to	e o o h be o en ed the e for	02/20/2013

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STATEMEN	STATEMENT OF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA		(X2) MULTIPLE CONSTRUCTION			(X3) DATE SURVEY		
AND PLAN OF CORRECTION IDENTIFICATION NUMBER:		IDENTIFICATION NUMBER:	A. BUILDING 00 COMPLETED			COMPLETED		
155298		A. BUII B. WIN			01/31/2013			
					ADDRESS, CITY, STATE, ZIP CODE			
NAME OF PROVIDER OR SUPPLIER								
DVD AMID DOINT DOOT A QUITE DELIADULITATION CENTED			,	8530 TOWNSHIP LINE RD				
PYRAMID POINT POST-ACUTE REHABILITATION CENTER			ζ	INDIANAPOLIS, IN 46260				
(X4) ID	SUMMARY STATEMENT OF DEFICIENCIES			ID	PROVIDER'S PLAN OF CORRECTION	(X5)		
PREFIX	`	(EACH DEFICIENCY MUST BE PRECEDED BY FULL		PREFIX	(EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA	COMPLETION		
TAG	REGULATORY OR LSC IDENTIFYING INFORMATION)			TAG	DEFICIENCY)	DATE		
	congestive hea	art failure and cirrhosis.			assess, measure, and provide			
	These diagnos	ses remained current at		appropriate fitting anti-embolic stockings.		;		
	the time of the	record review.						
					How the corrective action wi	"		
	Review of a lo	cal area physician			deficient practice does not			
		Summary," dated			reoccur?			
		14 p.m., indicated the			DON or designee will monitor			
					residents who wear anti-embo	olic		
		e documented] who			stockings for appropriate fit. T			
	presents with ascites. The patient				will be completed weekly time	s		
		y a primary care			four weeks and then monthly			
	provider. Initia	ll presentation was 6			times 2 months. At this time if			
	month(s) ago.	Presentation included			results are below a 95% thres			
	fluid weight ga	in. Past evaluation has			the audits will become weekly until a 95% threshold is achieved.			
	included albun	nin, complete blood			The results will be reviewed b			
	count and met				QAA committee monthly.			
	Treatment has	•			Date to be completed			
		furosemide [a diuretic			2/20/2013			
		-						
	_	Symptoms include						
		ention, weight gain and						
	peripheral ede	ma"						
	Nurses note, d	lated 12-22-12 at 6:30						
	a.m., "Residen	t wgt. [weight] 177.2,						
	increase 3.2 lb	s from yesterday.						
		es] to have 2+ edema						
	<u> </u>	ower extremities. TED						
		stockings] on. [Name						
	of physician] n	- -						
	or priyaidiaiij II	omieu.						
	Number	-t 40.00.40 -+ 40-40						
		lated 12-22-12 at 10:46						
		"BLE [bilateral lower						
	extremity] edema 2 + but Rt. [right]							
	thigh approx. [approximately] 3+.						
	TED hose are	too small, but they are						
	VI favitua laurua]. Removed at 2:15						

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AND PLAN OF CORRECTION IDENTIFIC		X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	X2) MULTIPLE CONSTRUCTION X3) DATE SU COMPLET A. BUILDING A. 24 (24 (2))		ETED		
		155298	B. WING			01/31/	2013
NAME OF PROVIDER OR SUPPLIER PYRAMID POINT POST-ACUTE REHABILITATION CENTER			8	3530 TC	DDRESS, CITY, STATE, ZIP CODE DWNSHIP LINE RD APOLIS, IN 46260		
(X4) ID PREFIX	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL			ID EFIX	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE		(X5) COMPLETION
TAG	REGULATORY OR	LSC IDENTIFYING INFORMATION)	T	AG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)		
	[sic] on Rt. thig 2. During an in	terview on 01-31-13 at					
	2:00 p.m., the Director of Nurses indicated she was unable to provide documentation the resident's						
		had been obtained ease in edema to the thigh.					
	company only vendor] and the extra large. W	F Nurses indicated "our uses [name of a certain e size only goes to e probably should have lering from some one					
	01-31-13 at 1:4	acility policy on 45 p.m., and undated, e Director of Nurses ollowing:					
	<i>Di</i> (0.0 : (20)	ONSIBILITY - Licensed sing Assistant, Other					
	lower extremiti circulation from	To provide support for es, to aid return n lower extremities, to us formation, to reduce ce edema."					
		T GUIDELINES - may					

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DEPARTMENT OF HEALTH AND HUMAN SERVICES CENTERS FOR MEDICARE & MEDICAID SERVICES

PRINTED: 02/20/2013 FORM APPROVED OMB NO. 0938-0391

	TOF DEFICIENCIES X1) PROVIDER/SUPPLIER/CLIA OF CORRECTION IDENTIFICATION NUMBER: 155298	(X2) MULTIPLE CC A. BUILDING B. WING	NSTRUCTION 00	(X3) DATE SURVEY COMPLETED 01/31/2013		
	PROVIDER OR SUPPLIER D POINT POST-ACUTE REHABILITATION CENTER	STREET ADDRESS, CITY, STATE, ZIP CODE 8530 TOWNSHIP LINE RD INDIANAPOLIS, IN 46260				
(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PRECEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)	(X5) COMPLETION DATE		
TAG	in physical and/or mental function, pain, rigidity, peripheral pulses, fever, change in skin integrity, color, temperature, edema, changes in condition of extremities." "PROCEDURE - 6. Notify physician if standard sizes will not fit: obtain order for custom-made gradient support stockings." This Federal tag relates to Complaint IN00121384. 3.1-37(a)	TAG	CROSS-REFERENCED TO THE APPROPRIA DEFICIENCY)			

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